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Filling the Gap

Examining the Downloading of Health Care Costs onto Alberta Municipalities

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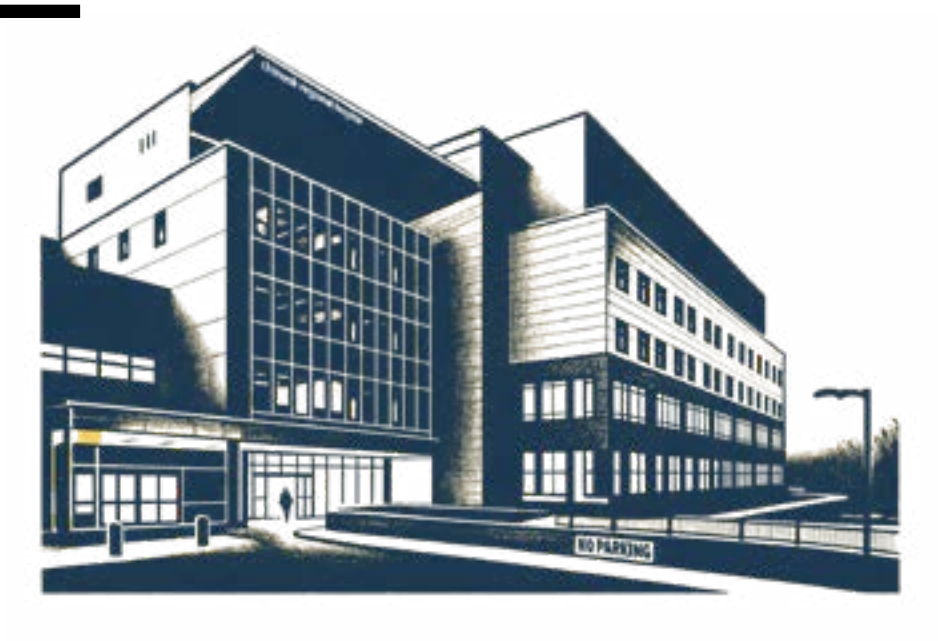

By now, it's redundant to say that Albertans are facing a crisis when it comes to accessing health care. With increased surgical wait times, worsening access to primary care, and a shortage of frontline workers, the challenges related to provision and delivery of health services in the province are multifaceted. What is often missed in these discussions, however, is who has begun to silently bear the cost of this crisis despite a lack of proper resources: local governments.

Under strenuous conditions, protecting and expanding access to health care has become an outsized concern for many Albertans [1]. Our universal health care system has struggled following decades of chronic under-investment and poor provincial coordination. The most troubling concern is the labour shortage of care providers, something that has significantly impacted various areas of care in communities across the province. According to the provincial government in 2024, over 700,000 Albertans do not have access to a primary care provider such as a family doctor or nurse practitioner (Government of Alberta 2024a). The under-staffing and under-resourcing of hospitals has left acute care in a crisis, with increasing wait times in emergency rooms and regular service disruptions in remote communities (Faubert 2025; Siever 2025). This had led to multiple high-profile system failures, most prominently demonstrated by the tragic case of Prashant Sreekumar,

1. Many polls show that health care remains among the top priorities of Albertans, if not the top issue. One Léger (2026) survey noted that 27% of respondents named health care as their top provincial issue — more than double the second most-named issue. A similar finding came from a Mainstreet Research (2026) poll that showed 22% of respondents listed health care as their greatest concern, second only to cost of living.

a 44-year-old man who died after waiting eight hours in an emergency room at the Edmonton Grey Nuns Community Hospital. A group of emergency physicians spoke out about six similarly preventable deaths that also occurred in the province's emergency rooms in the aftermath of Sreekumar's death into which the province has since launched a fatality inquiry (French 2026; Snowdon 2026). At the same time, surgical capacity in public hospitals has decreased as a result of government outsourcing to private charter facilities (see Longhurst 2023). Given these circumstances, Albertans are understandably concerned about whether they and their loved ones can reliably access care when they need it most.

Although health care is a provincial responsibility, the Alberta government's inadequate response to the health care crisis has resulted in municipalities increasingly assuming costs of providing health services. This is most acute in rural communities, where a lack of provincial investment and a severe physician shortage have forced many towns to fiscally support local health services. While this phenomenon has received occasional media coverage, it remains an understudied and sparsely understood aspect of Alberta's health care crisis.

This brief report is an initial step in closing this research gap, providing an overview of the primary ways that municipal governments are becoming involved in the provision of health services. An absence of provincial leadership means cities and towns are increasingly attempting to address problems, primarily through:

1) financial incentives for frontline health care workers; and
2) funding for local clinics and other health-related services.

Unfortunately, this is merely another step in a long history of Canadian governments "downloading" responsibilities onto municipalities through austerity and inaction (see Duffy et al. 2014). Without coordinated support and a workforce retention plan from the province, we run the risk of municipalities continuing to allocate limited financial resources towards health care rather than other local services.

Filling the Gap
Alberta Municipalities and Health Care

The history of municipal involvement in Alberta health care is a complex story. As "creatures of the province," Canadian municipalities lack clear jurisdictional boundaries and powers relative to other levels of government (see Sancton 2010). The case of health care policy is especially peculiar due to health services in the nineteenth and early twentieth century mainly being offered by a combination of private organizations and regional governments (Boychuk 1999, 10-11). Local municipalities initially played a significant role in the provision of Alberta's health care, as the difficulties of operating in rural and remote areas led to a lack of services from private for-profit and non-profit organizations. As a result, rural municipalities often paid for hospitals and voluntary municipal health care plans through specialized levies, with the provincial government offering partial subsidies to these local governments (Church and Smith 2022, 18-21). With the introduction of universal health care, however, hospitals and other health services became the purview of the provincial government. Communities would retain important decision-making abilities on their local hospital and public health boards, while the Alberta government set provincial standards and paid for the provision of services.

The 1990s saw significant change with the emergence of neoliberalism and the "downloading" of provincial responsibilities across Canada (see Melville 2006, 52-56). Although numerous definitions exist, neoliberalism broadly refers to a set of policies aiming at the expansion of the free market to all spheres of life through deregulation, lower taxation, and less government intervention. The popularity of this ideology among elected officials and bureaucrats during the 1990s led to a wave of neoliberal reforms in Canada.

The cost of these initiatives was typically borne through austerity and budget cuts at most levels of government, and municipalities were severely impacted by this wave

of reforms. Federal and provincial governments, trying to reduce spending after slashing taxes, downsized or "dumped" many functions traditionally done by them onto local governments "from education, to health care to policing" (Vengroff and Whelan 2001, 507). This was especially significant in Alberta, where the provincial government under Ralph Klein cut the Municipal Affairs budget by 35 per cent over two years, cut local grants for parks and services by 25 to 33 per cent, and privatized many services (504). Indeed, the provincial cuts to transfers became a "defining factor in Alberta municipal finance" throughout the 1990s and early 2000s (Lesage and McMillan 2009, 401-402). The austerity of the Klein government additionally resulted in a health care infrastructure deficit that Albertans continue to acutely feel across the province, with many cities and towns lacking the necessary number of hospitals for their populations (Church and Smith 2022, 191). Health care was a favourite target of the provincial government, with Klein frequently citing "rising costs" in health care as a reason for slashing the provincial budget (Taft 1997).

At the same time as neoliberalism was downloading costs onto local communities, the Alberta government had begun a restructuring of health care that amalgamated over 200 local hospital and public health boards into nine regional health authorities (Church and Smith 2022, 26-30). Some accused the government of pursuing this change to silence critics at the municipal level, who were more outspoken about how these policies were affecting their constituents (ibid). The regional health authorities centralized authority, shifting power away from local communities while at the same time offloading many of the costs of healthcare onto municipal governments. Eventually, the Progressive Conservative government would further amalgamate these nine health authorities into a single body for the province, Alberta Health Services.

Today, as a result of this structural disinvestment, the delivery of health care faces a variety of challenges. As Alberta's population grows, a greater strain is placed on our already overburdened and under-resourced health care system [2]. The infrastructure deficit has grown from a persistent issue to an outright crisis for local communities, as many Alberta towns lack the acute care services required to meet the medical needs of community members.

The Alberta government promises to address these shortcomings through new innovations in health care delivery, often justifying these changes by promising greater efficiency and less red tape (see Government of Alberta 2023; Johnson 2025). The danger, however, is that these changes do not address underlying systemic factors such as the province's workforce shortage or our infrastructure deficit. There are two key changes among the reforms proposed by the government. First is the dismantling of Alberta Health Services, the central provincial health authority previously responsible for the delivery of public care. It has

2. The population of Alberta has grown exponentially over the past five years. Examining the most recently published statistics as of publication, the provincial population grew 13.3% between October 2021 and October 2025 (Government of Alberta 2025).

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been replaced with four separate health agencies. Each of these agencies are based around the delivery of a specific type of care: primary care, acute care, containing care, and mental health and addictions. Finalized in 2025, this delivery model is unlike any other— something tacitly acknowledged by provincial bureaucrats who, during the announcement of the decision, could not cite another jurisdiction that uses a comparable model (French 2023).

The second major shift has been the increased privatization of care services. While previous provincial governments have pursued privatization, they largely stopped these changes after backlash from residents, civil society groups, and other levels of government (Church and Smith 2006). In contrast, the current United Conservative government has continuously enacted policies that greatly expand the scope for private, for-profit care providers. Two policies in particular warrant mention: the Alberta Surgical Initiative (ASI) and Bill 11. The ASI is a program that outsources publicly funded surgeries to private, for-profit surgical facilities. Introduced to improve care standards, studies have shown that the ASI has reduced surgical capacities in public hospitals, diverting resources away from public services and towards private operators. Advocates and public policy experts have also raised concerns about whether chartered facilities are charging higher fees for medical procedures, further diverting public funding away from frontline workers.

Bill 11: Health Statutes Amendment Act 2025 (no. 2) is a more overt introduction of private care, establishing a two-tier health care in Canada where a private market operates and competes alongside a public one. The legislation, passed in December 2025, fundamentally transforms many aspects of Canadian health care, allowing for "dual practice" where physicians can work in both the public and private sectors, encouraging private-pay insurance plans, and "muddying" the definition of a hospital to potentially allow for private operators (Longhurst and Graff-McRae 2026).

The primary concern arising from the province's reorganization of care delivery and increased privatization is that these changes divert limited resources and staff away from an already-struggling public system without addressing the underlying issues fuelling our existing problems. Without addressing the shortage of health care professionals and structural disinvestment from high levels of government, such policies divide an insufficient number of resources and staff among a greater number of service providers, while simultaneously undermining equal access to care. Unless greater action is taken, the systematic problems in our health care system will be exacerbated.

Filling the Gap
Municipalities and Health Care Policy

While the myth of health care privatization leading to efficiency persists, the reality is that the free market has never provided equitable access to health care, especially in rural communities. Without some degree of government intervention at the municipal or provincial level, most remote areas would remain chronically underserviced. Instead of collaborating with and adequately supporting rural communities, the current Alberta government is embracing increased privatization while often leaving municipalities and others to pay the price for this decision, either through municipal tax dollars or through a lack of care services.

In this context, we are already seeing costs passed down to local governments. Below, we examine two of the primary public policy tools used by municipal governments across the province to address serious problems in our health care system, such as physician shortages and declining access to care. In the absence of more comprehensive data, this report focuses on analyzing case studies throughout the province, gathered primarily through municipal documents and media reporting. What this reflects is a province-wide situation where cities and towns are increasingly pressured to intervene and support the provision of health care services despite their limited fiscal capacity.

Policy Tool #1: Financial Incentives for Health Care Professionals

Given over 700,000 Albertans were without a family doctor or primary care provider as of 2024, it is unsurprising that local governments are frequently becoming involved in the recruitment and retention of frontline health care workers (Government of Alberta 2024a). The provincial government previously released a 14-page "health workforce strategy" in 2024 but the report itself remains vague on specific policies or actions that would help alleviate the workforce shortage, consisting instead of broad "strategic focus areas" that lack accountable measures and initiatives (Government of Alberta 2024b). In the absence of a more comprehensive workforce plan, other actors have felt pressure to assume the responsibility for attracting and retaining health care providers. Many cities and towns have attempted to "woo" doctors and other care providers to their communities by providing recruitment incentives for workers who accept local jobs. Municipal or regional governments often accomplish this through the creation of recruitment and retention committees, which contain funds for competitive compensation packages or benefits, along with marketing campaigns.

From the research gathered to date, the County of Stettler offers the most generous compensation program through their Physician Recruitment and Retention Incentive (PRRI). Approved in 2023, the PRRI offers a one-time payment of at least $50,000 for candidate physicians who relocate to the County to offer basic medical services. The total value of the package can increase up to $70,000 if the candidate offers anesthesia or obstetrics, due to the severe shortage of physicians offering these services (County of Stettler 2025). Full payment of the incentive is contingent upon the physician offering services in the County for at least five years. As a district government, the revenue for this initiative is generated by each municipality providing $25,000 to $35,000 per physician when the placement is within their boundaries (Chambers 2025). Pressure for the PRRI came after a group of local volunteers formed Stettler Needs Doctors (n.d.) in 2024. At the time, the group estimated that six in 10 Stettler residents did not have access to a family doctor, as the community lost seven primary care physicians over the past two years (ibid).

Similar pressures also led to other communities initiating their own incentive programs. In May 2022, the Town of Fort MacLeod approved a $10,000 incentive for physicians who agree to practice for five years in the area. In media interviews, town officials emphasized that the town only had two phy-

sicians — only a third of the total number recommended for town of their size (Opinko 2022). In Northern Alberta, both the County and City of Grande Prairie offer a one-time financial incentive of $15,000 to physicians and nurse practitioners relocating to the region, with $10,000 coming from the county and $5,000 from the city (County of Grande Prairie 2025). Each worker must commit to practicing for at least three years or repay a prorated portion of the stipend. Cold Lake additionally facilitates a direct incentive program through the local nonprofit organization Hearts for Healthcare (n.d.), providing funding up to $20,000 for each health care professional who agrees to practice for three years in the area. Finally, Kneehill County also provides a $25,000 incentive for professionals through the Kneehill Medical Services Retention and Recruitment Task Force. Initially, the task force offered double the financial incentive but reduced it, finding that money incentives had limited impact on recruitment efforts and allocating funds to other strategies (Salkeld 2023).

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With more health care workers leaving Alberta for other jurisdictions, other municipalities are considering financial incentives, including Cochrane and Hinton (Edey 2022; Shokeir 2025). If more Albertans continue to lose access to primary care, it is likely that other cities, towns, and counties will pursue this policy tool as well despite its dubious efficacy.

Examining these cases, a clear pattern emerges. Public backlash over an increasing worker shortage in rural or remote areas leads municipal governments to offer direct financial incentives. Initial research calls the effectiveness of this policy into question. As noted in the above case of Kneehill County, their Task Force decided to allocate their resources to other approaches due to a lack of uptake among frontline workers. A 2022 survey conducted by the Rural Health Professions Action Plan (RhPAP), based in Edmonton, found that two-thirds of rural health care professionals said that financial incentives had "little or no influence on their decision to live and work in a rural community," despite financial incentives often remaining the "go-to attraction strategy" for many towns (RhPAP 2025, 69). While survey indicated that the tactic is more successful for retaining professionals already practicing in the region, a considerable number listed other issues as higher priorities (ibid). As noted by the report, this conclusion aligns with other research suggesting that financial incentives remain only one factor in the decision-making process of accepting a rural or remote position, with other communal aspects such as community safety, affordability, and access to social services being others (see Rourke et al. 2003; Verma et al. 2016; Holloway et al. 2020). Instead of focusing solely upon the financial dimension, regional partnerships and provincial investments in rural communities could strengthen recruitment efforts. Financial incentives also increase competition between municipalities for a limited supply of health care workers, producing a race to the bottom that is merely a short-term solution rather than a long-term strategy.

Although the above cases show many cities and towns turning to this policy tool, tracking the use of financial incentives remains

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difficult due to a lack of comprehensive data collection. To our knowledge, no level of government or non-governmental organization is publicly tracking the recruitment incentives offered by Alberta municipalities. In the absence of a compensative list or database, understanding and analyzing these incentives remains challenging. This is a familiar problem facing those studying municipal governance in Canada, as a lack of tangible data and the varying composition and structures of local governments often poses a barrier to research efforts. Additionally, this section does not factor in other recruitment initiatives potentially offered in individual physician contracts, such as transportation or housing costs. Nonetheless, beginning to track the use of incentives — both within Alberta and across the country — could provide a starting part to better comprehend the impact of these recruitment strategies and under what conditions municipalities implement them.

Policy Tool #2: Direct Investment into Health Care Clinics and Services

Due to the shortage of health care workers, many rural and remote communities suffer from long-term service gaps and inconsistent access to care. Overhead costs remain a considerable concern for primary care providers, with over nine in 10 family doctors surveyed by the Alberta Medical Association in 2024 saying they are concerned about the continued financial viability of their practices (ThinkHQ 2024). To alleviate this, many municipalities are providing operational funding for health care services, either subsidizing or outright purchasing local clinics to keep them solvent. Perhaps the most high-profile example of policy tool was when Hinton Town Council declared a "local health care crisis" in 2024 and approved spending $1 million over two years to keep their local clinic open. In a press release, the Town of Hinton noted that health care is a provincial responsibility but acknowledged that they have "seen the need locally" and that was in "the best interest of the community to do what we can" (Town of Hinton n.d.). In a subsequent media interview, then-Health Minister Adriana LaGrange said that, while they were exploring potential supports for the province, "what Hinton or any other community wants to do to make their community more attractive for a physician to come, that really is something that communities choose for themselves" (Johnson 2024). This reflects the growing reality that, in the absence of coordinated provincial action, many municipalities are being forced to address health care shortages themselves. In Hinton, this ultimately meant that the Hinton Healthcare Foundation — a local non-profit funded through primarily donations— eventually had to purchase the local clinic, with the support of the municipal government, to secure local services (Hinton Healthcare Foundation 2025; Town of Hinton 2025).

Another prominent case comes from Cold Lake, where the city purchased the existing Glacier Gate Medical Clinic for $1.85 million in 2023 (Bellefontaine 2023). The decision came after a 2022 census revealed that 40 per cent of residents did not have access to a family doctor. In purchasing the clinic, Cold Lake decided to run the clinic as a for-profit municipally controlled organization, giving them more direct influence over its operations. Through this, the then-mayor said he hoped that the municipally controlled clinic would be an opportunity to recruit new professionals to the area. The city currently operates the service as CL Medical Clinic and has seen some success in hiring new doctors (City of Cold Lake 2025).

Filling the Gap
Regional Advocacy and Information Sharing

A similar case emerged in northeast Alberta in 2025, when Wembley approved spending $150,000 to purchase medical supplies and secure a short-term lease for their town's only medical clinic (Garrett 2025). Originally opened in 2021, the clinic had initially closed only after four years in operation after one of their physicians left the area. Without the town intervening, the closure would have significantly impacted the ability of residents to reliably access primary care in the area. Only through providing financial support was the town able to save the Wembley Medical Clinic, keeping their doors open and assisting with the recruitment of three nurse practitioners.

Rather than purchasing entire businesses, some municipalities instead choose to subsidize clinic operations. Following the reallocation of funds away from the direct financial incentives discussed in the previous section, this is the path taken by Kneehill County and other municipalities. In 2024, the Country launched a three-year rent stabilization program for the Kneehill Medical Clinic (Kneehill County 2024). The program was created through a regional partnership between the County and the municipalities of Three Hills, Trochu, and Acme, totaling an overall investment of $90,000. In their announcement, the County said that the program was meant to alleviate financial pressures on the clinic, with the hopes that this would help attract and retain health care workers in the region.

Despite being a provincial responsibility, this report shows various ways that municipalities are increasingly becoming involved in the provision of health care. With increased public pressure over a shortage of frontline workers, especially in rural areas, it is understandable that many municipalities feel obligated to try improving the situation facing their constituents. Yet, given the financial constraints of municipalities, this may have unintentional implications for local governance. As resources allocated for other local services become redirected towards improving the health care system, it may lead to deficiencies elsewhere. More research is needed to comprehensively understand how municipalities are responding to local health care crises and the wholesale impacts that this "downloading" is having on their communities.

A potential area for municipalities to expand in this regard is through both coordinated regional advocacy and information sharing. During health care cutbacks in the 1990s and 2000s, municipal governments and civil society groups including Friends of Medicare became powerful actors in holding governments accountable and advocating for an improved public system (Bhatia and Coleman 2003, 734-735; Church and Smith 2006, 495-501). Collaborations between municipalities and civil society could similarly offer alternative paths forward, allowing for governments to identify shared needs and amplify calls for a coordinated workforce plan.

Municipalities also possess a unique ability to gather and disseminate information about their communities, which could strengthen calls for increased local investment from other levels of government. While many examples exist, two innovations are worth flagging. First is the Health Needs Assessment completed by the City of Beaumont (Richardson 2024). Through stakeholder engagement and public consultation, the city identified significant insights from residents about the types of health care they would like and ways to offer it that would best meet the community's needs. With this data, the municipal government has been able to advocate for specific investments and services, creating a long-term solution to address health-related problems in their city. Second is the budget "downloading" tracker initiated by the Town of Canmore. Following concerns over the cost of provincial governments downloading onto municipalities, Canmore instructed their town administration to track costs associated with downloading and annually present it to their finance committee. The report breaks down the annual cost by different lines, showing where each expense comes from. The latest report concluded that downloading will cost the town $10.7 million in 2026 (Lee 2025). Importantly, while these costs are not all related to health care, the annual Canmore report provides insights into the ways that local governments are picking up the tab for health care through things such as the fire department responding to EMS calls. Publicly publishing this information not only benefits local advocacy, but it also sheds light on how municipalities are assuming the cost of provincial inaction. Increased information sharing will help us better understand how downloading impacts local governance and what possible solutions exist to address the problems posed by it.

Filling the Gap
What is the Alternative?

What this report summarizes is how municipalities are beginning to assume costs associated with health care delivery. In the previous section, we discussed how coordinated advocacy and information-sharing remain powerful avenues for municipalities to spread awareness of this problem. To solve these issues, however, this advocacy must be targeted at tangible solutions and investments that the provincial government can provide. This section briefly examines what one potential alternative could look like and how it differs from the current approach championed by the province.

Although the current Alberta government has launched some initiatives to partially alleviate financial pressure on local communities, primarily through the Rural Team Recruitment Grant and the Rural and Remote Family Medicine Resident Physician Bursary Pilot Program, these programs do not represent a long-term solution (Government of Alberta 2025a). Whereas the first program provides funding to clinics and community organizations to partially cover the costs of primary team hires, the latter provides bursaries for resident placements in rural and remote areas. Together, the programs total $22 million to help rural communities recruit and retain physicians. Similar to other financial incentives, however, these programs do not resolve the underlying shortage of trained medical providers or address other non-financial factors impacting the recruitment and retention of workers. These programs additionally risk shifting the responsibility and cost of workforce recruitment onto rural communities, something emphasized by the response from the Rural Municipalities of Alberta (2024) to the implantation of these programs.

Building on calls from professional and civil society groups, what the province could do instead is develop and implement a comprehensive workforce plan. As mentioned early, the province's existing health workforce strategy remains rather broad and unconnected to specific policies or invest-

ments. In contrast to this, a more substantial plan should include measurable goals for workforce growth, outline specific policies aimed at improving recruitment efforts, and be connected to public funding for public services. This would help coordinate and distribute limited resources across the province, working to fill shortages and to recruit more workers without shifting the burden onto local communities.

The provincial government should develop this plan through dialogue with municipalities, professional associations, post-secondary institutions, health care unions, civil society groups, and everyday Albertans. Such a collaborative process could help build consensus about the direction of our health care system. Whereas repeated efforts to reorganize and privatize health care delivery has generated uncertainty and reflected a lack of long-term planning, a comprehensive workforce strategy could help cultivate stability for those working within the system, as well those accessing it.

While outlining such a plan is beyond the scope of this report, it is worth briefly outlining what such a document could potentially contain. To address workforce shortages, the province could make a substantial investment in training medical professionals within the province, patterning with universities and other post-secondary institutions to significantly expand existing programs and connect them to underserviced communities. Additionally, the plan should aim to close the infrastructure deficit in our communities, building new hospitals and public services where populations most need them and improving existing buildings to provide care for our increasing population. Finally, the plan should address the variety of factors that impact retaining and recruiting health care providers. In rural and remote areas, this likely means providing holistic investments to improve other public services, community associations, and the overall quality of life. This could help address the social and cultural factors that impact whether a physician decides to practice in an underserved community.

Altogether, a comprehensive workforce plan could represent a generational investment in our province, addressing existing problems and revamping our public services to ensure high-quality health care for all Albertans well into the future.

Filling the Gap
Conclusion

As Alberta's health care system continues to face many systemic problems and undergoes significant changes in the delivery of services, it is increasingly important to track and understand how these changes impact different levels of government. This report is an initial step in assessing how municipal governments are becoming involved in health care and what costs this poses for them. By gathering and analyzing cases from across the province, it has explained the primary ways that local governments have aimed to improve health services through offering direct financial incentives for workers and providing funding for clinics or other services.

An examination of the cases in this report shows that more research is needed to fully understand how recent changes to our health care system have impacted municipalities. Future directions for research could include a quantitative analysis of municipal budgets to examine how spending on health care services and recruitment programs have changed over time. Additionally, such an analysis could look at whether and how the cost of these initiatives has impacted funding for other services. Another avenue for further research would be qualitative interviews with municipal officials across the province, gathering their insights to better understand how downloading has affected local communities.

Importantly, any avenue for future research should also include an analysis of how downloading has impacted Indigenous peoples and communities throughout Alberta. The combination of anti-Indigenous racism and decades of underinvestment into rural, remote, and on-reserve communities has resulted in significant barriers to health care accessibility for Indigenous, First Nations, Métis, and Inuit peoples (Crowshoe et al. 2022, 2-3; Graff-McRae 2025, 9-10). Given the staffing and infrastructure gaps that exist, future research should consider the extent to which the costs of health care delivery are similarly downloaded onto First Nations reserves and Métis settlements.
Given the literature gaps that exist, this research is paramount. Without more information and analysis, we risk missing how municipalities have begun to quietly develop solutions aimed at improving the accessibility of health care in their communities and how this is more broadly changing the delivery of care in our province.

Filling the Gap
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